



FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

TESTIMONY OF
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HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON
INCOME SECURITY AND FAMILY SUPPORT

“IMPACT OF GAPS IN HEALTH COVERAGE ON INCOME SECURITY”

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Good morning Chairman McDermott, Ranking Member Weller, and members and staff of the Subcommittee on Income Security and Family Support. I am Bruce Lesley, President of First Focus, a bipartisan organization dedicated to making children and families a priority in federal policy and budget decisions. I have worked in federal, state, and local policymaking for 20 years, and most recently spent six years working for Senator Jeff Bingaman on the Senate Finance and Health, Education, Labor, and Pensions Committees.

I would like to thank the subcommittee and its members for bringing the important voice of children to this discussion, and also for your recent hearings on the health care needs of children in the child welfare system. I appreciate the opportunity to testify today about the financial problems confronting children and families in the health care system and to suggest possible policy solutions to help these families.

First Focus would like to make the following recommendations to help address the needs of uninsured or underinsured children and their families:

- 1) Congress and the President need to set aside ideological differences and, absent a national consensus, support state efforts to expand health coverage to Americans by a variety of means, including Medicaid and SCHIP, premium support, tax credits, and personal responsibility.
- 2) Congress should not take actions that would limit or restrict the ability of states to address their uninsured or underinsured problems.
- 3) Congress should provide leadership in a variety of areas for children, particularly for children with special health care needs, by passing mental health parity laws (H.R. 1424, S. 558) and legislation such as the “Keeping Families Together Act” (H.R. 687, S. 382).
- 4) Congress should make it a priority to gather better information, especially at the state and local level, regarding the health and well-being of America’s children, by passing legislation like the State Children Well-Being Research Act (H.R. 2477).
- 5) Since 62-75 percent of all uninsured children are eligible for but unenrolled in Medicaid and SCHIP, Congress should take up the President’s challenge when he ran for re-election to cover millions of these children by working with states to conduct extensive outreach and enrollment efforts, streamlining application and enrollment procedures, and making more extensive use of other needs-based public programs, such as school lunch programs, the food stamps program, Women, Infants, and Children (WIC), etc., to help identify and enroll children in Medicaid and State Children’s Health Insurance Program (SCHIP) through what is referred to as Express Lane Eligibility (ELE).
- 6) Congress should focus on the most disadvantaged youth in our nation and address gaps in health coverage for foster care children, including access to care, the needs of youth aging out of the child welfare system, and kinship care issues.

RECENT GROWTH IN RATE OF UNINSURED CHILDREN

According to the U.S. Census Bureau, 8.7 million or 11.7 percent of our nation’s children were without health coverage in 2006. The number of uninsured children had declined by about one-third since the creation of SCHIP a decade ago, but has in the past two years reversed course and increased by one million children. While the national trend is certainly alarming, a state-by-state look at the insurance status of children reveals trends that are, perhaps, of even greater concern. In 39 states and the District of Columbia, the percentage of children without insurance was higher in 2006 than it was in 2004 and in 29 states the rate increased by a full percentage point or more. I have included an analysis of these trends by First Focus as **Appendix A**.

While employer-sponsored insurance remains the predominate means of coverage for all non-elderly Americans, including children, the recent spike in the number of uninsured children is largely due to a drop of 1.2 percentage points in employer-sponsored coverage for children, from 60.9 percent to 59.7 percent. This decline is almost four times the rate of the drop in adult coverage of 0.3 percentage points, from 64.7 percent to 64.4 percent between 2005 and 2006.¹

The decline in employer-sponsored health coverage has been driven by three trends. First, more and more employers are simply deciding not to offer health insurance as a benefit. Second, the economy has been shifting such that more workers are employed by firms in industries that do not, generally, offer coverage. And finally, more employees have been declining an offer of coverage from their employers because of a variety of factors, including rising costs. These three trends have combined to produce a significant decline in employer-sponsored coverage, especially of children, at all income levels.

RISING HEALTH CARE COSTS LEADS TO FINANCIAL INSTABILITY

Children in middle-income families between 200 percent and 399 percent of the federal poverty level (approximately \$40,000 to \$80,000 for a family of four in 2006) account for 48 percent of the increase in the number of uninsured children, which is a population that largely does not have access to either Medicaid or SCHIP coverage.²

This drop in employer-sponsored insurance coverage for children suggests that dependent coverage is declining more rapidly than individual employee coverage. According to data from the Kaiser Family Foundation/Health Research and Education Trust (Kaiser/HRET) survey of employer-sponsored health benefits, the average annual cost for single and family coverage in 2007 is \$4,479 and \$12,106, respectively. Thus, the average cost for family coverage is 2.7 times the cost of individual coverage.

However, employers subsidize individual workers for coverage to a much greater extent than they subsidize family coverage. As a result, the annual premium contributions paid by individual workers average \$694, or 16 percent of the cost, compared to \$3,281, or 28 percent of the cost for family coverage. As a result, the average premium cost paid by workers for family coverage is 4.7 times the cost of individual coverage.³

Thus, family coverage is far more expensive than the cost of individual coverage. This is particularly true for smaller firms and businesses with a disproportionate share of low-wage workers where employees pay, on average, an even greater share of the cost of family coverage. For these workers, coverage costs are increasing even more rapidly than inflation or workers' wages.

In fact, according to data published in *Health Affairs*, between 2001 and 2007, health care premiums have increased 78 percent, while inflation increased by 17 percent and workers' wages increased by 19 percent.⁴

With both the employer- and employee-share of health care costs increasing by over four times the rate of general inflation, employers are increasingly passing on even a greater share of the costs to their employees, particularly for dependent coverage. For the four years between 2001 and 2004, health care premiums increased at more than 10 percent a year while worker earnings increased by only an average of three percent.

CAN MIDDLE-CLASS FAMILIES AFFORD THE RISING COST OF HEALTH INSURANCE?

Middle-class families across America are struggling for financial security. Each day they are faced with the prospect of being unable to afford basic necessities essential to their health and well-being. For many families, serious scrutiny is given to the costs of food, housing, transportation, and a host of other necessities, in order to balance their budgets. But, after providing for all of these necessities, the average family often has very little left over to afford the costs of even the most basic health care plan.

To more closely study this problem, First Focus recently conducted an analysis to illustrate the hardships that many of these families face on a monthly basis. The analysis below breaks down the budget for a family of two parents and two children living in various areas across the nation, at three different income levels:

1. Families earning 225 percent of the Federal Poverty Level (FPL), or approximately \$46,500;
2. Families earning 250 percent of FPL, or approximately \$51,625; and,
3. Families earning the median income for a particular area.

The analysis (see **Appendix B**) looked at 12 communities across the nation, including Chicago, Oakland, Atlanta, Las Vegas, Miami, and Washington, D.C. Expenses for the family budget were generated by the Economic Policy Institute's Family Budget Calculator.⁵ The monthly cost of private insurance was generated using the cheapest rate on www.ehealthinsurance.com for any health plan with a \$1,000 deductible and less than 20 percent coinsurance rate.

After taking into account expenses for a family's budget as well as the monthly cost of health insurance, the results indicate that families in a large majority of these 12 communities experience serious financial shortfalls each month even before attempting to pay premiums for a health care policy. In 11 out of 12 communities, those families earning the median income level are left with no money remaining, with some facing over \$1,500 in debts each month.

At 225 percent of FPL, in 8 out of 10 communities, families trying to afford the cost of health insurance also face serious debts each month. When earning 250 percent of FPL, only families in 3 out of 12 communities are in the red after purchasing health insurance. Even for those communities whose families would experience a surplus of funds the reality is that they would have very little left over, some as little as \$18.30, and most well under \$1,000. This small amount leaves very little cushion for medical expenses such as deductibles, prescriptions, and other costs incidental to medical care. Therefore, if anyone in a family gets sick, many are forced to cut costs from somewhere else within their budget, possibly from the cost of food, childcare, transportation, or rent.

Indeed, the data paint a rather bleak picture for today's middle-class, working Americans. In a significant majority of the income scenarios created in this analysis, working families are left with a negative amount of money after paying health insurance premiums each month.

This brief, snapshot analysis is indicative of an urgent problem facing every region in America – a growing population of working-class families who do not qualify for public health programs, but cannot afford coverage in the private sector, and lack access to private health insurance. This

coverage gap is becoming an even more serious problem, and it is where many of America's children are falling through the cracks.

The result is that families are increasingly faced with a "triple threat" to their financial security in the form of a limited family budget confronted with large annual increases in premiums, increases in other forms of cost-sharing such as co-payments and deductibles, and health benefit limitations. And with fewer employers offering coverage, families are facing the "ultimate threat" to financial and income security – having no insurance at all or being forced to pay out of pocket for exorbitant health care costs.

Due to the greater health and financial insecurity faced by many Americans, the latest poll by Kaiser Health Tracking found that health care is the top domestic issue and second only to Iraq as the issue that the American public wants the President and Congress to address. In that poll, the cost of health care and health insurance and expanding health insurance coverage for the uninsured were identified by the public as the top two issues that Presidential candidates need to address.⁶

As for the issue of children's health, Republican pollster Frank Luntz reported similar results in a poll that he conducted for First Focus in July that found that 90 percent of Americans support the notion that every child in America has a right to basic health care, with 76 percent of Americans strongly supporting the idea. Furthermore, by a 77-16 percent margin, Americans were supportive of legislation aimed at reducing the number of uninsured children, with nearly 60 percent strongly supporting this proposal.⁷

THREATS TO INCOME SECURITY FOR THE UNINSURED AND UNDERINSURED

Health care coverage and income security often work in tandem either to improve the physical and financial well-being of individuals or by contributing to a downward spiral that threatens both physical health and income security.

In a *Health Affairs* article, it is noted that 16 percent of families spend more than 5 percent of their income on health care and between 8 and 21 percent of American families are contacted by collection agencies about their medical bills on an annual basis.

Moreover, of the 3.9 million people involved in personal bankruptcy filings in 2001, it was estimated that 1.3 million, or one-third, of them were children. The authors estimate that medical problems contributed to about half of all the bankruptcies and cited that "illness begot financial problems both directly (because of medical costs) and through lost income."⁸

The authors found that "a second common theme was sounded by parents of premature infants or chronically ill children; many took time from work or incurred large bills for home care while they were at their jobs." It is significant to add the point that, "among those whose illnesses led to bankruptcy, out-of-pocket costs averaged \$11,854 since the start of illness" and that "75.7 percent had insurance at the onset of illness."⁹

Thus, it is not just the uninsured who are threatened with financial ruin. Those who have insurance but are underinsured represent more than three-quarters of the filed bankruptcies related to medical reasons.

AFFORDABILITY OF HEALTH COVERAGE FOR CHILDREN WITH SPECIAL NEEDS

Affordable and comprehensive health insurance is clearly an important factor in protecting both the health and well-being of families but also their financial security. Unfortunately, an accident, catastrophic or chronic illness, or a job loss can quickly threaten the health and financial security of a family. This is often the everyday story for children with special health care needs.

Children with special health care needs are, by definition, those children who have health problems that result in greater needs and services than other children. They have health care costs that are three times greater than the costs for children without special health care needs. These children face problems including discontinuity of coverage, inadequate coverage of needed services, inability to obtain referrals to appropriate specialists because of insurance plan limitations, and inadequate provider payment levels and thereby access to care.¹⁰

As Alex Chen and Paul Newacheck note, “more so than other children, [children with special health care needs] require services that may or may not be covered under commercial health insurance plans, as well as out-of-network services that require higher copayments. Furthermore, children with special health care needs by definition utilize those services at greater frequencies than other children, thus incurring greater out-of-pocket expenses. These cost-sharing responsibilities and out-of-pocket expenses can result in significant financial burden, particularly for poor families.”¹¹

Chen and Newacheck s found a close association between a child’s poor health and reduced parental employment. According to the two California doctors, “...these families are often faced with the reality of one or both parents cutting back work. Cutting back or stopping work can also lead to a significant decrease in family income level as the result of lost wages, thus placing these families in a downward financial spiral.”

Chen and Newacheck added, “the proportion of families with children with special health care needs who reported parents needing to stop work or cut back on work in order to care for their child was 29.9 percent. The overall proportion of families who reported having financial problems due to their child’s care was 20.9 percent.”¹² The result is a downward trend as a child’s health care needs create increasing financial problems or, even worse, parents are forced to quit work or work part-time to care for a child, thereby increasing both the gaps in health coverage and financial hardship simultaneously.

As Amy Davidoff of the Urban Institute points out, private non-group insurance coverage is difficult to obtain for children with any major chronic condition or disability due to medical underwriting and preexisting condition exclusions that are often allowed by state regulation.¹³ Furthermore, as parents attempt to deal with increased medical costs and workforce instability due to having a child with a chronic health care condition, they also find themselves struggling with health care problems, including poorer mental health and increased stress.¹⁴

In addition, parents of children with special health care needs face other challenges. In the workforce, “...parents indicated that they were reticent about disclosing family circumstances to their employer....,” according to Dr. James Perrin and other researchers. “Parents feared reprisal – loss of their job, a promotion, or career opportunities or being perceived as a ‘problem’ employee. Some were reluctant to appeal a claim or make their health insurance coverage needs known, for these same reasons.”¹⁵

CASE IN POINT: CHILDREN WITH MENTAL HEALTH CARE NEEDS

Families often have so few resources to turn to for help that, in the case of children with mental health problems, a survey by the National Alliance for the Mentally Ill (NAMI) reported that 23 percent of parents with children exhibiting behavioral disorders reported being instructed to relinquish custody of their children in order to ensure they receive appropriate mental health care treatment.

As Darcy Gruttadaro of NAMI explains, “Theoretically, families should be able to access services for children with serious mental illnesses through existing systems -- private health insurance, Medicaid, special education, and/or the child welfare system. The reality is that these systems have repeatedly failed families and their children with severe mental illnesses. Private health insurance is often not an option for families with a seriously mentally ill child because policies place severe restrictions on benefits for the treatment of mental illnesses. Medicaid, the Individuals with Disabilities Education Act (IDEA) and other programs designed to provide and/or finance services for children with serious mental illnesses have also fallen well short of the mark. The unfortunate result is that parents and caregivers, who are repeatedly denied services for a child with a mental illness, may be forced to enter the juvenile justice or child welfare system just to access critically needed services. These families may ultimately face custody relinquishment.”¹⁶

The General Accounting Office adds, “Multiple factors influence parents’ decisions to place their children in the child welfare or juvenile justice systems so that they can obtain mental health services for them. Private health insurance plans often have gaps and limitations in the mental health coverage they provide...and not all children covered by Medicaid received needed services.”¹⁷

No family should ever face such a decision. While insurance coverage is clearly very important in helping to prevent this tragic decision, insurance must be adequate to truly provide children and their families the health care they need. For these reasons, First Focus supports legislation to improve the adequacy of both private and public health care coverage, such as mental health parity for private health plans, the “Keeping Family Together Act” (H.R. 687) (sponsored by Congressman Ramstad, Stark and Kennedy) intended to ensure that parents have access to treatment for their severely emotionally disturbed children, and mental health parity within the public programs, including Medicare, Medicaid, and SCHIP.

HOW DO CHILDREN FARE IN YOUR STATE?

That’s an excellent question, and one to which we cannot have very specific answers. For a variety of reasons, when it comes to children’s well-being, the data can be quite spotty. There are plenty of studies, public and private, that focus on the health care needs of adults, but children are often overlooked. Furthermore, even in the several studies that do cover children, the results can rarely be broken down by state, and we know very well that national trends often do not reflect what is happening in regions or states.

As we move forward in trying to improve the well-being of children, it is crucial to recognize that each state has its own needs. Unfortunately, when it comes to the needs of children, we are woefully uninformed. Any effort to improve the well-being of children should start with gathering better information on how our kids are faring right now. H.R. 2477 (co-sponsored by Congressman Camp and Congressman Stark), which is before this very subcommittee right now, would accomplish this

important goal. The State Child Well-Being Research Act would direct the Department of Health and Human services to conduct an annual state level survey of dozens of child-well being indicators. This crucial survey would yield a treasure trove of information about our nation's children which will prove invaluable to state and federal policymakers. This survey will offer a far better understanding of how differences in health access can impact the overall well-being of children and families and how these effects vary across states.

Good policy requires good information, and right now, sadly, we are without a lot of good information on the state level. This committee would be taking an important step forward for the health and welfare of America's children by passing the State Child Well-Being Research Act.

CROSSING THE IDEOLOGICAL DIVIDE

To address the problems of being uninsured or underinsured in America, it will take a combination of all approaches – government-purchased private coverage, premium subsidies, sliding-scale subsidies or income-related tax credits, health insurance market reforms, purchasing pools, high-risk pools, individual responsibility, and improved access to safety net providers – to improve coverage and access to care for children.

Government-purchased private coverage could be improved by addressing problems with continuity, access to care, and enrollment. On this latter point, economists Julie Hudson and Tom Selden at the Agency for Healthcare Research and Quality (AHRQ) note that, as of 2005, 62 percent of all uninsured children are eligible for but unenrolled in either Medicaid or SCHIP. The authors write, “Of these [children], 36.1 percent were in families with incomes below poverty, and another 41.1 percent were in families with incomes of 100-200 percent of poverty...Clearly, this group includes some of the most disadvantaged children in the United States.”¹⁸

Therefore, the uninsured rate for children could be significantly reduced if the federal government and states would work together to conduct extensive outreach and enrollment efforts¹⁹, streamline applications and enrollment procedures, and make more extensive use of other public programs, such as school lunch programs, the food stamps program, Women, Infants, and Children (WIC), etc., to help identify and enroll children in Medicaid and SCHIP. This is called Express Lane Eligibility and is bipartisan legislation sponsored by Senators Richard Lugar (R-IN) and Jeff Bingaman (D-NM) in the Senate and is included in the various SCHIP reauthorization bills that have been debated before Congress.²⁰

The other 38 percent of children need some sort of financial assistance to help make employer-sponsored or non-group health insurance coverage more affordable. For these children, states should be provided a variety of tools to expand SCHIP coverage, increase premium assistance programs, and to encourage personal responsibility for health coverage. With federal financial support, the State of Massachusetts expanded SCHIP coverage for children, increased their premium assistance program, reorganized their health insurance pooling and purchasing arrangements, and imposed an individual mandate for those that can afford to purchase coverage on their own.

The federal government should encourage such innovation by other states rather than restricting options for states to embark on coverage expansions or imposing their own one-size-fits-all solution on the country. Both the David and Lucille Packard Foundation and the Robert Wood Johnson Foundation have embarked on multi-million dollar initiatives at the state level to reduce the number of uninsured children or uninsured Americans, respectively. In the absence of consensus at the

national level, the federal government should support initiatives like these at the state and local levels and, at the very least, not restrict or foreclose options available to the states.

Furthermore, the federal government should also provide families with the option of tax credits to help purchase non-group coverage directly. In formulating such a tax credit, the federal government should not impose the credit in lieu of other options, such as SCHIP coverage or premium assistance. The credit should be another option available to families. However, the credit should address problems with current health care tax credit proposals that provide an amount for families that is only two times the amount for individuals. In light of the fact that coverage for a spouse alone doubles the cost of health insurance, such tax credit proposals fail to recognize that family coverage is 2.7 times the cost of individual coverage in the private marketplace. As a result, children are completely left out of the credit and that must be addressed.²¹

ADDRESSING THE HEALTH CARE NEEDS OF CHILDREN IN FOSTER CARE

And finally, this Subcommittee has had several outstanding hearings in the last few months regarding the health care problems facing foster care children that I would like to underscore today. These children have very unique health care needs that are far greater than even those experienced by other children living in poverty. In fact, nearly half of children in foster care experience a chronic medical condition and close to 80 percent suffer from a serious emotional disorder. As Dr. David Rubin of the American Academy of Pediatrics noted in his testimony before this subcommittee, these conditions are often “under-identified and under-treated.”

Addressing the health care needs of foster children is a priority for First Focus and we welcome the opportunity to work with the subcommittee to address these issues, including the promotion of kinship care in a manner that helps the 2.5 million grandparents and other relatives who are responsible for meeting the basic needs, including the health care needs, of these children.

Kinship care is the fastest growing form of placement for children in foster care, and we are especially concerned with ensuring access to coverage for children living with relative caregivers. Kinship caregivers typically live in poverty, and struggle to support themselves and the children they care for. They are often older, retired and living on fixed incomes. In fact, an Urban Institute study found that nearly two-thirds of children in kinship care live in families with incomes below 200 percent of FPL. One-third of children live in families with incomes below 100 percent of FPL.²²

Children living with relatives are also less likely to access health care. A 2001 Urban Institute report found that only 49 percent of children in informal kinship care arrangements actually received the Medicaid health insurance coverage they were entitled to, which is why outreach is critical for this population.²³ Often, kinship caregivers are unaware that there are free and affordable children’s health insurance programs available through Medicaid and SCHIP, or that they can apply for the programs on behalf of the children in their care. Enhancing services, training, federal financial assistance, and outreach to kinship care are critical to ensuring that our system of care adequately meets the needs of our most vulnerable children.

We support efforts to expand and improve resources for relative caregivers, which is why we support the Kinship Caregiver Support Act (H.R. 2188, S. 661). We are especially pleased that the bill establishes a Kinship Guardianship Assistance Program that will help ensure permanent homes for some children living with relatives by providing states the option to use federal funds for subsidized guardianship payments to relative caregivers on behalf of children they have cared for in foster homes

and are committed to caring for permanently outside of the formal child welfare system. We look forward to working with you on this critical issue and others to improve the health of our nation's children.

Thank you Mr. Chairman and members of the subcommittee for the opportunity to testify before you today.

NOTES

¹ John Holahan and Allison Cook, “What Happened to the Insurance Coverage of Children and Adults in 2006?”, Kaiser Commission on Medicaid and the Uninsured, September 2007.

² Ibid.

³ Ibid.; Gary Freed and Kathryn Fant, “The Impact of the ‘Aging Of America’ On Children,” Health Affairs, Vol. 23, No. 2, March/April 2004; and, Gary Claxton, et al, “Health Benefits in 2007: Premium Increases Fall To An Eight-Year Low, While Offer Rates and Enrollment Remain Stable,” Health Affairs, Vol. 26, No. 5, September/October 2007.

⁴ Claxton, et al.

⁵ For specific methodology, please visit <http://www.epi.org/content.cfm/bp165>.

⁶ Kaiser Health Tracking Poll: Election 2008, “Iraq Remains Top Issue for Public; Health Care Now Ranks Second Overall, Including Among Republicans,” Issue 4, October 2007.

⁷ Luntz, Maslansky Strategic Research, “Making Children a Priority: Survey 2007” for First Focus, July 2007 (see at www.firstfocus.net/Download/CHIPPoll.pdf).

⁸ David Himmelstein, et al, “Illness and Injury As Contributors to Bankruptcy,” Health Affairs, Web Exclusive, February 2005.

⁹ Ibid.

¹⁰ Alex Chen and Paul Newacheck, “Insurance Coverage and Financial Burden for Families of Children with Special Health Care Needs,” Ambulatory Pediatrics, Vol. 6, No. 4, 2006; and, Michael Kogan, Paul Newacheck, et al, “Association Between Underinsurance and Access to Care Among Children With Special Health Care Needs in the United States,” Pediatrics, Vol. 116, No. 5, November 2005.

¹¹ Chen and Newacheck.

¹² Ibid.

¹³ Amy Davidoff, “Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance,” Pediatrics, Vol. 114, No. 2, August 2004.

¹⁴ James Perrin, et al, “Benefits for Employees with Children with Special Needs: Findings From the Collaborative Employee Benefit Study,” Health Affairs, Vol. 26, No. 4, July/August 2007.

¹⁵ Ibid.

¹⁶ Darcy Gruttadaro, National Alliance for the Mentally Ill, “The Tragedy of Custody Relinquishment,” NAMI website, http://www.nami.org/Content/ContentGroups/Legal/The_Tragedy_of_Custody_Relinquishment_-_NAMI_Legal_Center.htm

¹⁷ General Accounting Office, “Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services,” GAO-03-397, April 2003.

¹⁸ Julie Hudson and Thomas Selden, “Children’s Eligibility and Coverage: Recent Trends and a Look Ahead,” Health Affairs, Web Exclusive, August 16, 2007.

¹⁹ President George W. Bush, “President’s Remarks at the 2004 Republican National Convention,” Madison Square Garden, New York, NY, September 2, 2004 (from transcript on White House website at <http://www.whitehouse.gov/news/releases/2004/09/20040902-2.html>). According to the President, “America’s children must also have a healthy start in life. In a new term, we will lead an aggressive effort to enroll millions of poor children

who are eligible but not signed up for the government's health insurance programs. We will not allow a lack of attention, or information, to stand between those children and the health care they need." This promise was included as part of the President's FY 2006 budget "Cover the Kids" proposal, which would have provided \$1 billion in grants over two years in "a new campaign to enroll millions of more low-income children in Medicaid and the State Children's Health Insurance Program" (see www.whitehouse.gov/omb/budget/fy2006/hhs.html).

²⁰ To address this issue, Senators Lugar (R-IN) and Bingaman (D-NM) have introduced S. 1213, the "Children's Express Lane to Health Coverage Act of 2007." Additional information can be found at <http://www.firstfocus.net/pages/3137/>.

²¹ Stan Dorn, "A Brief Analysis of the Bush Administration's Tax Proposals in the Context of SCHIP Reauthorization," August 1, 2007 (see <http://firstfocus.net/pages/3248/>); and, James Capretta, "Effective Healthcare Reform States with a Tax Fix," Tax Notes, May 21, 2007.

²² Jennifer Ehrle and Rob Geen, *Children Cared for by Relatives: What Services Do They Need?* (Washington, DC: The Urban Institute, June 2002, Series B, No. B-47),

²³ Jennifer Ehrle, Rob Geen, and Rebecca Clark, *Children Cared for By Relatives: Who Are They and How are They Faring* (Washington, DC: The Urban Institute, February 2001).